

Good Day Senators.

On behalf of the Oregon Hospice Association and Providence Health System, I want to thank you for the opportunity to speak to you today on the important issue of barriers to hospice care.

First a brief introduction. My name is Karen Bell. I am a nurse with 37 years of nursing experience, the past 24 years in home health and hospice. Currently, I am Director of Hospice for the Providence Health System, in Portland, Oregon. Providence is a Catholic health care organization with facilities and programs in five Western states. (Oregon, Washington, Alaska, California, and Montana.)

Oregon hospices, along with other hospices in the United States, recognize an urgent need for changes in the Medicare hospice benefit. At the same time, however, we wish to honor the vision that created this benefit for the Medicare population.

The continuation of a Medicare hospice benefit is vital to individuals with a life-threatening illness, but the economic reality is, if this benefit is not modernized, Medicare patients will no longer have access to hospice care.

This must be prevented. It is time to update this program!

Oregon hospices are reporting significant decline in the length of stay of patients admitted for care.

This has had a devastating effect for every hospice, from the smallest rural hospice to the largest metropolitan programs. None of us can continue to sustain the significant cost of short-term patient care when the average break-even point is estimated at more than 31 days.

>Moreover, the current reimbursement for hospice care does not take into consideration the added burden borne by rural hospices. Even though their volume of patients is small, their territory or service area they must cover is large, and yet their reimbursement is less than in larger metropolitan areas.

All 56 hospices in the State Of Oregon have had the opportunity to make contributions to the "Hospice Program Improvement Act of 2000". Input on the proposal has also been received from other health care professionals: physicians, pharmacists, case managers, home health providers and the community.

The consensus of all these groups is that there are six key barriers to hospice care in Oregon.

In all parts of Oregon, and frequently in the more rural counties, the primary health care provider is a nurse practitioner. These individuals currently work under the umbrella of a physician, but in many cases the physician has not seen the patient, doesn't know the patient and may even live and work in a different community. To ask this physician to sign the documents citing the patient as having a limited life expectancy and any subsequent orders is unjust and unreasonable. However, under the current Medicare Conditions of Participation, the medical doctor must sign the document or the patient cannot be accepted into hospice. A barrier is created that precludes them from accessing the hospice Medicare entitlement program.

Nurse practitioners can admit patients to the hospital, they can manage their care in private practices, sign orders and make changes to the patient's plan of care without a physician co-signing, but they cannot admit patients to hospice.

>Also, it is noteworthy that the metropolitan areas of Oregon experience the same challenges and must

cope with the frustration of Nurse Practitioners who are primary care providers for a patient and yet cannot make a referral to hospice.

Second, the current Conditions of Participation require a member of the core team be a social worker (BSW or MSW). In many parts of Oregon, this can be a challenge. Qualified social workers are simply not available in all counties, or it may take months for a social worker to be recruited for a hospice. Currently the hospice program Conditions of Participation dictate that no hospice program could be developed or remain operational without a social worker as an employee of the hospice program.

Third, there is the question of time. It is difficult for a patient and family to learn that there are no further treatment options available to them. What the physician *can* offer to them is hospice care to ensure that the end of their life has quality, dignity and that their final wishes will be respected. Even for the most skilled physician, a discussion on end of life care takes time, usually more time than the physician has available during a routine office visit.

It is very appropriate that the physician broach this topic with their patient. However, physicians need to be able to offer to the patient a personal visit with a hospice professional to review the concept of hospice care and provide more information on what the Medicare hospice benefit can offer.

A hospice professional is also the best person to explain the complexities of the Medicare hospice benefit. The Medicare hospice benefit can be difficult to understand and, to add to the complexity, if the patient is enrolled in a Medicare HMO they will remain in the HMO for all care not related to their terminal diagnosis but revert to the non-HMO Medicare benefit for hospice care.

As you are well aware, seniors are very protective and concerned about their Medicare benefit. A hospice professional that understands the intricacies of this benefit and can provide informed answers is in the best position to have this discussion and can ensure that eligible seniors do not forego this vital benefit out of misguided fear or simple confusion.

Unfortunately, the current Benefit does not reimburse hospices for informational or consultative visits. This is a financial burden that few hospices can carry. We welcome the opportunity to explain hospice care and to permit patients and families to consider this option, but we need to be paid for our time and efforts.

Fourth, short stay patients, defined by most hospices as under 14-day length of stay, are very costly for hospice programs. The admission visit may involve not only the hospice nurse but also a social worker. The first days after admission to hospice are intense; the hospice team evaluates the patient and family needs and a plan of care is established. Frequently, durable medical equipment, such as a hospital bed, commode, or wheel chair, is needed to aid in the provision of care; also pain and symptom management frequently necessitates changes in the medication regime.

Recognition that the patient may have a fairly short length of stay usually results in an increased frequency of visits from most, if not all members of the hospice team. The current Medicare benefit reimburses hospices for each day the patient is enrolled, making no provision for intensity of the services provided or the increased costs associated with these services. Because the patient is on service for a short period of time, the hospice team must try to condense the support, education and training to the family into fewer, but lengthier visits. Hospice programs report the reimbursement for the majority of short stay patients' falls far short of the cost of the care provided.

If a patient has another care provider, such as home health, the decision may be made to not admit the

patient to hospice care. Few, if any, hospice programs want to acknowledge that they may make the decision not to admit the patient due to concern for inadequate reimbursement, but it is a factor that each program must consider. Resources in hospice are not unlimited, and hospices must make their admission decision based on their program's long-term survival so they can continue to provide hospice care to other seniors.

The minimum payment for 14 days of care, regardless of the length of service for the hospice patient as proposed in the "Hospice Program Improvement Act of 2000" would provide much needed stability to the hospice program. This would also ensure access for Medicare beneficiaries seeking the benefit, particularly in rural areas of the country.

Fifth, under the current Conditions of Participation a hospice is required to contract for inpatient respite care with a facility that has 24-hour registered nurses on-site. This requirement hurts those patients who live in communities that do not have a skilled nursing facility, or where respite beds are not available.

Under the Conditions of Participation, the hospice program is in charge of the patient's plan of care and hospice nurses must be available 24 hours per day, seven days of the week.

Sixth, patients with a limited life expectancy may continue to receive active treatment, the primary goal being to extend their life. For example, chemotherapy, blood transfusion, radiation therapy, all of which may be appropriate for the patient's condition but which disqualify them from hospice care. Some of these treatment decisions, however, are inconsistent with what they say they would want at the end of life.

Acceptance of a poor prognosis, and coming to terms with the fact that you have a terminal diagnosis is not simple. Many people need time and support to work through their conflicting emotions, and time to consider and evaluate the benefit/burden of the treatment options. >

The supportive and comfort care benefit in the "Hospice Program Improvement Act of 2000" would provide these patients with guidance while they are still making decisions about treatment options and with the support and services of hospice-trained staff while they are undergoing active treatment to extend their life. At such time as their treatment options become palliative, their care can be transitioned into the Medicare hospice benefit.